#38 (252), 8 November 2004

A publication of the International Centre for Policy Studies

ICPS newsletter®

Reforming healthcare: Slovak experience, recommendations for Ukraine

To eliminate the demographic crisis that Ukraine is facing today, the country needs to improve its healthcare system. Funding for this area can be improved by introducing a system of medical insurance, reducing the role of state funds in financing medicine, and setting conditions that will attract private capital to the market. These and other recommendations were presented by a former finance minister of Hungary, Lajos Bokros, under a joint ICPS and INEKO (Slovakia) project for transferring know-how in reforming the healthcare system in the Visegrad Four

Ukraine is ready for healthcare reform

In Ukraine, economic growth has reached unprecedented high levels and fiscal equilibrium has largely been restored. Ukraine can now afford to spend substantially more on maintaining and improving general public health standards, including prevention of epidemics such as HIV/AIDS and tuberculosis, discouraging smoking and drinking, and so on. This is indispensable to fight demographic decline and increase life expectancy for new generations. Primary care should be better equipped to diagnose serious illnesses and determine more precisely the correct treatment for patients in secondary and tertiary facilities.

Privately funded and managed insurance companies should compete for patients' money, while secondary and tertiary healthcare providers (specialists and intensive hospital care) should compete for contracts with insurers. When supported by powerful professionals, the position of patients vis-a-vis physicians can be considerably stronger and, thus, the quality of services can be expected to substantially improve.

The financing of healthcare should also change over time. Healthcare contributions paid by employers need to be reduced and the overall amount of such contributions should be in line with the costs of providing basic services for all working people. A low, flat healthcare tax should be levied on all individual incomes to underpin social solidarity in the system. In addition, all individuals should be able to choose among competing healthcare insurers and buy various levels of coverage for themselves and their families. The State Budget will obviously remain responsible for providing funds to both the state healthcare fund and private insurers on behalf of all those without a regular income, such as women on maternity leave, and so on. It makes sense to consider introducing co-payments for doctor visits, no matter how symbolic these might be. This is key to preventing overuse of primary care and reducing the pace of growth in the use (and abuse) of prescription drugs.

In addition, the financing of in- and out-patient care facilities needs to be even more decentralized, in order to improve the management and control of these institutions. After careful planning and analysis, the introduction of mandatory private health insurance should be seriously debated. This will substantially improve the level of awareness among the general public of the real cost of healthcare—and provide considerable incentive for "self care."

How the Visegrad 4 countries started out

When the first democratically-elected governments took power in these countries, privatization was high on the political agenda. However, privatizing social services, including healthcare was extremely controversial. Physicians themselves were very much divided as to

Attention journalists!

In order to improve the quality of economic policy debate in Ukraine, five analytical briefs have been prepared. These briefs discuss the business environment, tax reforms, poverty alleviation, healthcare and pension system reforms in Eastern European countries and include recommendations for Ukraine. They can be downloaded at *www.icps.kiev.ua/project.html?pid=67*.

Prepared under the auspices of a joint project between International Centre for Policy Studies and the Institute of Economic and Social Reform (INEKO) in Bratislava, the authors are leading researchers and politicians from Poland, Slovakia, Hungary and the Czech Republic. They are prepared to comment for Ukrainian journalists on the exprience of economic reform in their countries, to provide advice on reforms in Ukraine, and to respond to general questions about the economies of Slovakia and other Central European countries who joined the EU this year. You can turn to the authors directly via e-mail:

- **Poverty Alleviation:** Miroslav Beblavy (Beblavy@employment.gov.sk), State Secretary, Ministry of Labor, Social Affairs and Family of Slovakia
- **Healthcare:** Lajos Bokros (Lbokros@worldbank.org), former Finance Minister of Hungary
- **Tax Reform:** Maciej Grabowski (maciej.grabowski@ibngr.edu.pl), Vice President, Institute of Market Economy Research, Poland
- **Pension Reform:** Eugen Jurzyca (jurzyca@ineko.sk), Director, Institute of Economic and Social Reform (INEKO), Slovakia
- **Business Environment:** Jan Mladek (VELKY.MEDVED@seznam.cz), Deputy, Czech Parliament

what part of their profession should be subject to market forces.

Introducing the concept of the family doctor. Reforms started with the privatization of the business of general practitioners (GPs), so-called "house doctor" practices which are the usual point of entry for patients into the healthcare system. In most cases, the actual privatization did not require any physical sale of large equipment but only a new licensing system for the practice. This first tier of healthcare was also regarded as best provided by doctors licensed by local authorities at the lowest level of government. So the lowest level of local governments acquired the right to issue licenses and auction off practices wherever there was potentially more than one taker.

Financing for GPs changed for the better. Patients now have the right to choose among a good number of certified doctors. This has given rise to a certain level of competition, which reinforces incentives for quality improvements.

Free entry of private capital to healthcare services. Another important aspect of early reforms was the possibility of establishing new institutions for any level of healthcare. However, these new establishments remained on the fringes of healthcare because people did not have much money to pay for all the costs and most of those who did tended to still use their connections and influence to get reasonably acceptable quality treatment at state-owned healthcare facilities—at the expense of the health insurance fund. Still, private capital found valuable market niches, especially in high tech intensive areas of in- and out-patient care. Meanwhile, the state-run social insurance funds started to pay partly for a number of services offered by private clinics, since this helped alleviate the burden of state providers whose capacities were highly overstretched.

Rationalization of state insurance fund management. While rationalization of slack capacity did not yield too many tangible results because of heated political opposition and professional resistance (most physicians resisted losing their legal status as civil servants with all the attached prerogatives and privileges), governments were successful in rationalizing the management and administration of the health insurance funds. Typically, these were the largest extrabudgetary funds in the fiscal sector, after pensions.

The details of healthcare financing

Co-payments as a measure to limit excess demand. Only in Slovakia was the government able to introduce a much-debated co-payment system for both visits to GPs and outpatient care facilities and daily fees for staying in hospitals. That seems to be key to limiting unnecessary visits, superfluous check-ups and over-prescription. This last led to a marked reduction of drug overuse, which is quite rampant in the V4.

Identifying basic and supplementary services. The concept of separating these two sets of healthcare services cannot be overemphasized. The general public needs to accept that the scope of state-funded healthcare is not unlimited and that universal entitlement does not imply an inalienable right to get all types of healthcare services without any consideration as to costs.

Cataloguing and categorizing healthcare services. The new Slovak legislature has mandated its Government to set up a commission to describe all illnesses and therapies very precisely in each and every case. This is indispensable for the insurance system (both public and private) to assess its ultimate financial obligation, but it is also invaluable for physicians to calculate what amount of insurance income they are entitled to get for each individual exam and course of treatment. Categorizing healthcare services, in turn, is vital for patients, as it defines the share of payment (both insurance and co-payment) required from them.

A multi-source system of financing with mandatory private health insurance. This arrangement can be similar to what is already widespread practice in reformed pension systems: multi-source financing offered by strong private institutions defending the interests of patients while competing for their money. As time goes by and the newly-created health insurance supervisory system acquires teeth and invaluable experience, more and more of what is now covered by state-owned insurers could be ceded to competing private health insurance providers.

Competition among in- and out-patient care facilities. The debate over privatizing hospitals and outpatient clinics remains heated. It must be emphasized that the ownership of secondary (specialized) and tertiary (intensive care) providers is much less important than the issue of their financing. Without fostering serious competition among hospitals and clinics, it is impossible to improve the quality of their services and they will not be interested in cost control at all. Competition can be created through free entry and exit and full liberalization of ownership, without necessarily obligating existing providers to privatize.

Decentralizing secondary and tertiary care. Most hospitals and outpatient clinics will likely remain in the hands of local or regional governments. In V4 countries, most notably in Poland, where the government decided to decentralize the management of the state health insurance fund, hospitals and larger outpatient care units are now managed at the regional level. In smaller countries like the Czech Republic, Hungary and Slovakia, there is no obvious anchor level for managing larger healthcare providers in the government hierarchy. Still, decentralization is both possible and desirable. ■

This text is abridged from a policy brief by Lajos Bokros, Central European University (Hungary). For the complete version, see http://www.icps.kiev.ua/project.html?pid=67.

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To be included in the distribution list, mail your request to: marketing@icps.kiev.ua.
icps newsletter editor: Yevhen Shulha (shulha@icps.kiev.ua)
Phone: (380-44) 236-4477, Fax (380-44) 236-4668
English text editor: L.A. Wolanskyj
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